

# OUTPATIENT HOSPITAL SERVICES PAYMENT SYSTEM

*payment***basics**

Medicare beneficiaries receive a wide range of services in hospital outpatient departments, from injections to complex procedures that require anesthesia. Spending for these services has grown rapidly, largely because of changes in technology and medical practice that have lead to new services and encouraged shifts in care from inpatient to ambulatory care settings. Outpatient hospital care accounted for \$18 billion (about 6 percent) of total Medicare spending in 2004.

Medicare originally based payments for outpatient care on hospitals' costs. The Balanced Budget Act of 1997 (BBA) almost completely eliminated cost-based payments by requiring the Centers for Medicare & Medicaid Services (CMS) to develop an outpatient prospective payment system (OPPS). CMS began using the OPPS in August 2000. In 2004, about 4,300 hospitals provided OPPS services, and about 47 percent of beneficiaries received at least one OPPS service.

The BBA also established a system that would over time steadily reduce beneficiaries' copayments for services provided under the OPPS. Under the cost-based system that preceded the OPPS, copayments had become nearly 50 percent of Medicare payments to hospitals for outpatient care. Under the OPPS, copayments will decline as a share of total OPPS payments until it reaches 20 percent. In 2004, beneficiaries' copayments accounted for 34 percent of total payments under the OPPS.

In many respects, the OPPS is a fee schedule. It sets payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices. Hospitals also can receive additional payments in the form of outlier adjustments for extraordinarily high-cost

services and pass-through payments for some new technologies.

When CMS began using the OPPS, the new payment system had the potential to substantially reduce hospital payments below the amounts under the cost-based system. In response, the Congress at least partially protected some hospitals from financial losses through "transitional corridor" and "hold harmless" provisions. The Congress has legislated permanent hold-harmless status to cancer and children's hospitals. In addition, small rural hospitals and rural sole community hospitals (SCHs) have hold-harmless status through 2005. In 2006, rural SCHs will receive an additional 7.1 percent above standard OPPS payment rates on all OPPS services except drugs and biologicals.

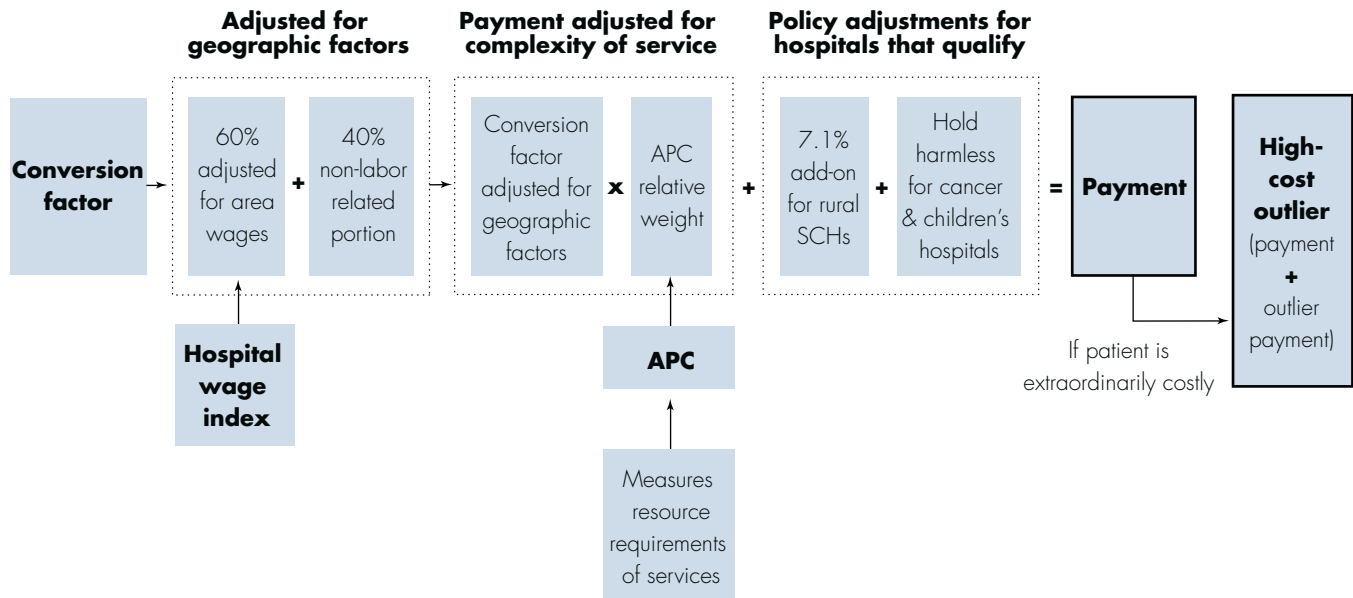
## **Defining the outpatient hospital products that Medicare buys**

The unit of payment under the OPPS is the individual service as identified by Healthcare Common Procedure Coding System codes. CMS classifies services into ambulatory payment classifications (APCs) on the basis of clinical and cost similarity. All services within an APC have the same payment rate. In addition, CMS assigns some new services to "new technology" APCs based only on similarity of resource use. CMS chose to establish new technology APCs because some services were too new to be represented in the data the agency used to develop the initial payment rates for the OPPS. Services remain in these APCs for two to three years, while CMS collects the data necessary to develop payment rates for them. Each year CMS determines which new services, if any, should be placed in new technology APCs. Payments for new technology APCs are not subject to budget neutrality adjustments, so they increase total OPPS spending.

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**Figure 1 Outpatient hospital services prospective payment system**



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system.

Within each APC, CMS packages integral services and items with the primary service. In deciding which services to package, CMS considers comments from hospitals, hospital suppliers, and others. In response to these comments, CMS pays separately for:

- corneal tissue acquisition costs,
- blood and blood products,
- some observation services, and
- many drugs.

While CMS makes most OPPTS payments on a per service basis, CMS pays for partial hospitalizations on a per diem basis. The per diem rate represents the expected costs for a day of care in the facilities that provide these services, hospital outpatient departments and community mental health centers.

### Setting the payment rates

In setting the payment rates in the OPPTS, CMS intends to cover hospitals' operating and capital costs for the services

they furnish. CMS pays separately for professional services, such as physician services. CMS determines the payment rate for each service by multiplying the relative weight for the service's APC by a conversion factor (Figure 1). The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC.

The conversion factor translates the relative weights into dollar payment rates. To account for geographic differences in input prices, CMS adjusts the labor portion of the conversion factor (60 percent) by the hospital wage index. CMS does not adjust the remaining 40 percent.

CMS initially set the conversion factor so that projected total payments—including beneficiary copayments—would equal the estimated amount that would have been spent under the old payment system, after correcting for some anomalies in statutory formulas.

One exception to CMS's method for setting payment rates is the new technology APCs.

CMS assigns services to new technology APCs on the basis of cost information collected from applications for new technology status. New technology APCs encompass cost ranges from \$0–\$50 to \$9,500–\$10,000. CMS sets the payment rate for a new technology APC at the midpoint of its cost range.

Hospitals can also receive three payments in addition to the standard OPPS payments:

- pass-through payments for new technologies,
- outlier payments for unusually costly services, and
- hold-harmless payments for cancer and children's hospitals, sole community hospitals located in rural areas, and all other rural hospitals with 100 or fewer beds.

In addition to new technology APCs, pass-through payments are another way that the OPPS accounts for new technologies. In contrast to new technology APCs—which are payments for individual services—pass-through payments are for specific drugs, biologicals, and devices that providers use in the delivery of services. The purpose of pass-through payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS payment rates. The Balanced Budget Refinement Act of 1999 (BBRA) said that payments for pass-through drugs must be based on average wholesale prices (AWPs). However, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the basis of payment to the drugs' average acquisition prices. For pass-through devices, CMS bases payments on each hospital's costs, determined by adjusted charges to costs using a cost-to-charge ratio.

Total pass-through payments cannot be more than 2 percent of total OPPS payments in 2004 and beyond. Before the start of each calendar year, CMS estimates total pass-through spending. If this estimate exceeds 2 percent of estimated

total OPPS payments, the agency must reduce all pass-through payments in that year by a uniform percentage to meet the 2 percent threshold.<sup>1</sup> Also, CMS reduces the conversion factor to make pass-through payments budget neutral.

CMS also makes outlier payments for individual services that cost hospitals much more than the payment rates for the services' APC groups. In 2006, CMS defines an outlier as a service with costs that exceed 1.75 times the APC payment rate and exceed the APC payment rate by \$1,250. For a service meeting both thresholds, CMS will reimburse the hospital for 50 percent of the difference between the cost of furnishing the service and 1.75 times the APC rate. For 2006, CMS is limiting aggregate outlier payments to 1 percent of total OPPS payments. CMS will make the outlier payments budget neutral by reducing the conversion factor by 1 percent.

The OPPS has permanent hold-harmless status for cancer and children's hospitals. In addition, rural SCHs and other rural hospitals with 100 or fewer beds have hold-harmless status through 2005. If PPS payments for these hospitals are lower than those they would have received under previous policies, CMS provides additional payments to make up the difference. Finally, CMS will add 7.1 percent to the OPPS payments for services furnished by rural SCHs beginning in 2006, excluding drugs and biologicals. CMS will make these additional payments to rural SCHs budget neutral by reducing payments to all other hospitals by 0.4 percent.

CMS reviews and revises the APCs and their relative weights annually. The review considers changes in medical practice, changes in technology, addition of new services, new cost data, and other relevant information. The BBRA requires CMS to consult with a panel of outside experts as part of this review. CMS also annually updates the conversion factor by the hospital market basket index, unless the Congress stipulates otherwise.

### **Additional changes in the Medicare outpatient PPS**

The MMA introduced several changes to how Medicare pays for drugs under the OPPS. For 2004 and 2005, the legislation enacted payment rates for many separately billable drugs that are tied to the drugs' AWP as of May 1, 2003. These rates apply to separately paid radiopharmaceuticals and to drugs and biologicals that were pass-through items prior to January 1, 2003.

For 2006, the MMA requires CMS to pay for these drugs at the drugs' average acquisition cost. CMS has determined

that the payment rates for these drugs will equal 106 percent of the drugs' average sales price. In addition, CMS will make separate payments for the costs hospitals incur in handling the drugs.

Finally, the MMA mandated that separate APCs be established for drugs and biologicals that cost at least \$50 per administration in 2005 and 2006 and excluded separately paid drugs and biologicals from outlier payments. ■

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<sup>1</sup> CMS did not impose uniform payment adjustments from August 2000 through April 2002, even though pass-through payments exceeded the statutory limit.